Sanjay Aggarwal MD, PA
Board Certified in Lung & Sleep Disorders
215 Oak Dr South Ste. H
Lake Jackson, TX 77566
PH: (979) 297-1007/ FAX: (844) 573-3211

PATIENT INFORMATION

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Mailing Address:	
Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**	
Home #: **Work #:**	**Cell:** **Would you like to receive text msg's?** ☐ Yes ☐ No *(msg rates may apply by your wireless carrier)*
Emergency contact: **Relation:**	**Contact phone #:**
Primary insurance:	**Member ID #:**
Secondary insurance:	**Member ID #:**
Email: **Enable patient portal?** ☐ Yes ☐ No *(access to electronic medical records)*	
Family Physician:	**Referring Physician:**

NEW PATIENT QUESTIONNAIRE

Please state the reason for your visit today:	**List any doctors you have seen within last 3 years:**

PAST MEDICAL HISTORY

List your medical problems:

Please list any hospital visits within the last 6 months (include inpatient, outpatient, emergency care)

Month	**Reason**	**Hospital**

Have you received any of the following vaccines?

Pneumonia vaccine: ☐ No ☐ Yes Date:	Flu vaccine: ☐ No ☐ Yes Date:
Covid vaccine: ☐ No ☐ Yes Moderna/Pfizer/J&J Date:	

PAST SURGICAL HISTORY

List surgeries & approx. date:

PATIENT NAME:

Local Pharmacy: *(list name & city)*

Mail-in Pharmacy:

Allergies to medications:

Name the Drug	Reaction You Had	Name the Drug	Reaction You Had
1)		4)	
2)		5)	
3)		6)	

List prescribed drugs and over-the-counter drugs, such as vitamins and inhalers you are currently taking:
If you have a current medication list, attach to paperwork or hand it to the receptionist

Medication name	Strength	Frequency	Medication name	Strength	Frequency
1)			16)		
2)			17)		
3)			18)		
4)			19)		
5)			20)		
6)			21)		
7)			22)		
8)			23)		
9)			24)		
10)			25)		
11)			26)		
12)			27)		
13)			28)		
14)			29)		
15)			30)		

CONSENT FOR TREATMENT

- → I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Sanjay Aggarwal MD, PA and clinical personnel.
- → I consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Sanjay Aggarwal MD, PA Notice of Privacy Practices.
- → I authorize payment of medical benefits to Sanjay Aggarwal MD, PA for services rendered.
- → I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my treatment.
- → Patients under the age of 18 must be accompanied by parent or guardian.
- → I consent to receive, by cellular phone and/or other telephone number(s) that are provided to Sanjay Aggarwal MD, PA or updated at a later time, text messages and/or telephone calls, email or any other computer-aided technologies from Sanjay Aggarwal MD, PA clinical providers, and business associates. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered.

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Acknowledgement of Notice: Signature Date

NOTICE OF PRIVACY PRACTICE

We are required by law to maintain the privacy of our patients with respect to protected health information. If, after given the Notice of Privacy Practices, you have any objections to that form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Your signature below is an acknowledgement of our Notice of our Privacy Practices and that you consent to the use and disclosure of your medical information. These authorizations will remain in effect until terminated by the patient, the patient's personal representative, or another individual legally authorized to do so by court order. The patient has the right to revoke or terminate these authorizations by submitting a written request to: Sanjay Aggarwal MD, PA 215 Oak Drive South Suite H, Lake Jackson, TX 77566.

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Print legal name: Date